The House Committee on Health and Human Services offers the following substitute to HB 628:

A BILL TO BE ENTITLED
AN ACT

To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to provide for health care data to be made available to consumers; to provide for definitions; to provide for criteria for the website available to consumers; to provide for reporting to the Department of Community Health by heath care facilities regarding acquired infections and adverse incidents; to provide for rights of citizens to health care information; to amend Article 6 of Chapter 4 of Title 26 of the Official Code of Georgia Annotated, relating to pharmacies, so as to provide for pharmacies to submit performance and outcome data to the Department of Community Health; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by designating the existing provisions of Chapter 5A, relating to the Department of Community Health, as Article 1 and adding new articles to read as follows:

"ARTICLE 2

31-5A-30.

This article shall be known and may be cited as the 'Health Care Quality and Transparency Act.'

31-5A-31.

As used in this article, the term:

(1) 'Acquired infection' means any localized or system patient condition that resulted from the presence of an infectious agent or agents, or its toxin or toxins, as determined by clinical examination or by laboratory testing and was not found to be present or

incubating at the time of admission unless the infection was related to a previous admission to the same setting.

(2) 'Health care facility' means those facilities defined pursuant to Code Section 31-6-2, including hospitals, ambulatory surgical facilities, freestanding imaging centers providing outpatient services, nursing homes, personal care homes, hospices, and home health agencies.

(3) 'Health insurer' means any health care corporation as defined in Code Section 33-20-3, any managed care entity as defined in Code Section 33-20A-3, any health maintenance organization as defined in Code Section 33-21-1, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(4) 'Home health agency' shall have the meaning set forth in paragraph (2) of Code Section 31-7-150.

(5) 'Hospice' shall have the meaning set forth in Code Section 31-7-172.

(6) 'Indigent person' means any person having as a maximum allowable income level an amount corresponding to 125 percent of the federal poverty guideline.

(7) 'Nursing home' shall have the meaning set forth in paragraph (3) of Code Section 31-8-163.

(8) 'Pharmacy' shall have the meaning set forth in Article 1 of Chapter 4 of Title 26.

31-5A-32.

(a) The department shall develop a website supporting health care transparency so that consumers of the State of Georgia may access information to perform a comparative analysis of the cost and quality of health care provided in this state. In making the health care information available on the website, the department shall:

(1) Provide for the website to be organized in a manner that enables the public to use it easily;

(2) Exclude from the website any information that compromises patient privacy;

(3) Include links to websites of health care facilities to enable the public to obtain additional information about health care facilities, including programs designed to enhance quality and safety;

(4) Allow other websites, in the department´s discretion, to link to the website for the purposes of increasing the website´s availability;

(5) To the extent possible, include state and federal benchmarks for the performance measures; and

(6) Clearly identify the sources of data used in the website and explain the methodology used to develop the performance measures.

(b) Each health care facility shall submit, when applicable, a report to the department which includes, but is not limited to:

(1) A copy of the balance sheet, including a statement describing the hospital's total assets and total liabilities, including captive corporations, nonprofits, foundations, and other entities with like board members;

(2) A copy of the income statement;

(3) A statement of changes in financial position;

(4) A statement of changes in fund balance;

(5) Accountant notes pertaining to the report;

(6) Net patient revenue; and

(7) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) Revenue from state programs;

(D) Revenue from local government programs;

(E) Local tax support;

(F) Charitable contributions;

(G) Other third-party payments;

(H) Gross inpatient revenue;

(I) Gross outpatient revenue;

(J) Contractual allowance;

(K) Any other deductions from revenue;

(L) Charity care to indigent persons, including the number of persons treated; the number of inpatients and outpatients; total patient days; total number of patients categorized by county of residence; and the indigent care costs incurred by the health care facility by county of residence;

(M) Itemization of bad debt expense;

(N) The public, profit, or nonprofit status of the health care facility and whether or not the health care facility is a teaching hospital;

(O) The number of board certified physicians, by specialty, on the staff of the health care facility;

(P) The number of nursing hours per day for each hospital and per patient visit for each ambulatory surgical or obstetrical facility;

(Q) For ambulatory surgical or obstetrical facilities, the types of surgery performed and emergency back-up systems available for that surgery;

(R) The availability of emergency services, trauma centers, intensive care units, and neonatal intensive care units for hospitals;

(S) Procedures health care facilities specialize in and the number of such procedures performed annually;

(T) Cesarean section rates by number and as a percentage of deliveries for hospitals; and

(U) Depreciation expenses based on the expected useful life of the property and equipment used.

(c) Each health care facility shall submit to the department, in a manner prescribed by rules and regulations of the department, data which include, but are not limited to:

(1) Data available on a recognized uniform billing statement or substantially similar form generally used by health care facilities which reflect, but are not limited to, the following types of data obtained during a 12 month period during each reporting period:

(A) Unique longitudinal nonidentifying patient code;

(B) The patient´s birth date, sex, race, geopolitical subdivision code, ZIP Code, and county of residence;

(C) Type of bill;

(D) Beginning and ending service dates, date of admission, discharge date, and disposition of the patient;

(E) Principal and secondary diagnoses and principal and secondary procedures and procedure dates;

(F) External cause of injury codes;

(G) Diagnostic related group (DRG) number and DRG procedure coding used;

(H) Revenue codes and total charges and summary of charges by revenue code;

(I) Payor or plan identification, or both;

(J) Place of service code such as the uniform hospital identification number and hospital name; and

(K) Attending physician and other ordering, referring, or performing physician identification number, and specialty code; and

(2) Aggregate data, which include, but are not limited to:

(A) Case mix data;

(B) Hospital admission data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level;

(C) Number of patients treated as a result of a transfer from another hospital;

(D) Data on health care facility acquired infections, including Class I surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, and other categories of infections that may be established by rule by the department;

(E) Data on complications and readmission data with patient and provider specific identifiers included; and

(F) Price lists which shall include but not be limited to:

(i) Usual and customary room and board charges for each level of care within the hospital, including, but not limited to, private rooms, semiprivate rooms, other multiple patient rooms, and intensive care and other specialty units;

(ii) Rates charged for nursing care; and

(iii) Usual and customary charges, stated separately for inpatients and outpatients if different charges are imposed, for any of the following services provided by the health care facility:

(I) The 30 most common x-ray and radiological procedures;

(II) The 30 most common laboratory procedures;

(III) Emergency room services;

(IV) Operating room services;

(V) Delivery room services;

(VI) Physical, occupational, and pulmonary therapy services; and

(VII) Indication as to whether the charges listed include fees for the services of hospital-based anesthesiologists, radiologists, pathologists, and emergency room physicians.

(d) In addition to the data set forth in subsections (b) and (c) of this Code section, hospitals, ambulatory surgical facilities, nursing homes, home health agencies, hospices, and personal care homes with 24 beds or more shall be required to submit to the department in a format as prescribed by rules and regulations information regarding:

(1) Percent of occupancy;

(2) Data regarding staff, which includes:

(A) The number of licensed and unlicensed staff directly responsible for the care of the patient; and

(B) Languages spoken by staff;

(3) Data on types of services provided;

(4) Data from admission assessment that reflects:

(A) Medical condition of a patient;

(B) Most frequently reported medical condition of patients;

(C) Most frequently reported medical condition of patients receiving a change in assessment; and

(D) The percentage of patients who require no assistance, limited assistance, or extensive assistance with respect to mobility, eating, and other basic life functions;

(5) Data regarding patient utilization of Medicaid, medicare, or other insurer;

(6) Data regarding percentage of patients who are private payors;

(7) Data regarding key deficiencies resulting from complaint investigation and number of uncorrected deficiencies;

(8) Data regarding terminations from Medicaid or medicare programs and reasons for terminations;

(9) Data regarding number of locations by county;

(10) Discharge data indicating the inpatient facility from which the patient originated such as a hospital, rehabilitation facility, nursing home, or other entity and the reason for discharge as well as data regarding the discharge disposition of the patient subsequent to receipt of care;

(11) Average length of stay by age group;

(12) Average number of hours per home health visit based on diagnosis;

(13) Utilization data including the number of patients who are readmitted for service;

(14) Number of admissions to acute care and reasons for admissions;

(15) Number of deaths by age groups and race or ethnicity;

(16) Indicators of the nature and amount of nursing care directly provided by licensed nurses, including, but not limited to, the average ratio of registered nurses to patients and the average skill mix ratio of licensed and supervised unlicensed personnel to patients;

(17) Medication errors, number and grade of pressure sores, number of injuries, number of nosocomial infections and number of preventable hospitalizations;

(18) Documentation of defined nursing intervention such as clinical assessment by a licensed provider, pain measurement and management, skin integrity management, patient education, and discharge planning; and

(19) Documentation of patient safety measures such as restraint checks, seizure precautions, and suicidal precautions.

(e) In addition to the data prescribed in subsections (b) and (c) of this Code section, ambulatory surgical facilities and imaging centers providing outpatient services shall provide data regarding:

(1) The 30 most commonly performed services provided in a nonoffice setting;

(2) The 30 most commonly performed services provided in an office setting;

(3) Medicare and Medicaid participation;

(4) The ten most common clinical presentations requiring diagnostic imaging and for each category the number of patients that received imaging examinations and the average charge for the examination;

(5) Other such data which are reasonably necessary to study utilization patterns as required by department rules and regulations; and

(6) Certification of data submitted by the appropriate duly authorized representative or employee of the health care facility that the information submitted is true and accurate.

(f) Health insurers shall be required to submit to the department as prescribed by rules and regulations information regarding claims, premium, administration, and other financial information. Data submitted shall be certified by the chief financial officer or his or her designee.

(g) In addition to the data prescribed in subsections (b) and (c) of this Code section, imaging centers providing outpatient services shall provide a report which includes:

(1) Average patient volume for imaging per month;

(2) Documentation noting the frequency of inspections of x-ray equipment, ultrasound equipment, and nuclear imaging equipment and the individual performing the inspection;

(3) Hours of operation and number of certified radiologists on site;

(4) Number, type, and age of diagnostic imaging equipment, including magnetic strength, when applicable, and whether the diagnostic imaging equipment is fixed or mobile;

(5) The number of procedures performed by CPT code;

(6) The number of repeat procedures taken which were conducted in order to obtain a sufficient image relating to the patient´s image order;

(7) The number and type of complications associated with sedation and the administration of contrast agents;

(8) The number of patients who required hospitalization as a result of a complication within 24 hours of a procedure;

(9) The number of diagnostic procedures performed and the number that revealed negative findings; and

(10) The number of clinical images audited and the number of cases in which there was a variance between audited findings and the original findings.

(h) Data submitted to the department by health care facilities or health insurers shall not include specific provider contract reimbursement.

(i) The department shall identify those prescription drugs for which price information shall be collected from pharmacies in accordance with Code Section 26-4-119. Such information shall include the usual and customary price, known as the retail price. If the drug is available in generic form, price data shall be reported for the generic drug and brand-name equivalent.

(j) Specifications for data to be collected under this Code section shall be developed by the department with input from the Health Information Technology and Transparency

Advisory Board, or its successors, established affected entities, consumers, purchasers, and such other interested parties as may be determined by the department. The department shall determine which medical conditions and procedures, performance outcomes, and patient charge data to include on the website. When determining which conditions and procedures to include, the department shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, whether the condition is acute or chronic, variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which performance outcomes to include, the department shall consider such factors as volume of cases, average patient charges, average lengths of stay, complication rates, mortality rates, and infection rates, among others, which shall be adjusted for case mix and severity, if applicable; provided, however, that the department may also consider such additional measures that are adopted by the federal Centers for Medicare and Medicaid Services, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the federal Agency for Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care facilities or such additional measures adopted by other states. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies, consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the department. When determining which patient charge data to include, the department shall consider such measures as average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

(k) The department shall have the right to review any and all documentation upon which data submitted are based upon reasonable notice and in accordance with department rules and regulations.

(l) Portions of patient records obtained or generated by the department containing the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person, or any other identifying information which is patient specific or otherwise identifies the patient, either directly or indirectly, are confidential and exempt from disclosure.

(m) In the event that the department does not receive from a health care facility or health insurer the data as required by this article, the department shall notify the health care facility or health insurer regarding the deficiencies, by certified mail or statutory overnight delivery, return receipt requested. In the event that the deficiency continues for 15 days after said notification has been given, the department may fine the health care facility or health insurer in an amount not to exceed $1,000.00 per day for every day that the violation exists and continues for the first 30 days, an amount not to exceed $5,000.00 per day for

every day that the violation exists and continues beyond the first 30 days and through 60 days, and an amount not to exceed $10,000.00 per day for every day that the violation exists thereafter.

31-5A-33.

(a) Each health care facility shall furnish to the department a report regarding acquired infection that shall include the specific infectious agents or toxins and site of each infection, the clinical department or unit within the facility where the patient first became infected, the patient´s diagnoses and any relevant specific surgical, medical, or diagnostic procedure performed during the current admission.

(b) Health care facilities shall be required to report information to the department on hospital acquired infections that involve:

(1) Surgical site infections;

(2) Ventilator-associated pneumonia;

(3) Central line-related bloodstream; and

(4) Any other category prescribed by the rules and regulations of the department.

(c) The department shall establish rules and regulations outlining guidelines, definitions, criteria, standards, and coding for hospital identification, tracking, and reporting of acquired infections which shall be consistent with the recommendations of recognized centers of expertise in the identification and prevention of acquired infections, including, but not limited to, the National Health Care Safety Network of the Centers for Disease Control and Prevention or its successor.

(d) The department shall collaborate with the Health Information Technology and Transparency Advisory Board, its successor, and other interested groups to evaluate the quality and accuracy of data reported under this Code section and the data collection, analysis, and dissemination methodologies.

(e) The department shall be authorized to use the data for the transparency website created pursuant to Code Section 31-5A-32. The information on acquired infections shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies. The acquired infection data shall be organized so that a comparative analysis may be performed among health care facilities with respect to infection control.

(f) The department shall be prohibited from disclosing the annual report, or any portion thereof, that contains information that directly or indirectly identifies a patient, employee of a health care facility, or licensed health care professional in connection with a specific acquired infection incident.

(g) In the event that the department does not receive from a health care facility or health insurer the data as required by this article, the department shall notify the health care

facility or health insurer regarding the deficiencies, by certified mail or statutory overnight delivery, return receipt requested. In the event that the deficiency continues for 15 days after said notification has been given, the department may fine the health care facility or health insurer in an amount not to exceed $1,000.00 per day for every day that the violation exists and continues for the first 30 days, an amount not to exceed $5,000.00 per day for every day that the violation exists and continues beyond the first 30 days and through 60 days, and an amount not to exceed $10,000.00 per day for every day that the violation exists thereafter.

31-5A-34.

(a) Each health care facility shall submit a report to the department regarding adverse incidents in a manner prescribed by department rules and regulations. Adverse incidents shall be defined as:

(1) Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient;

(2) Surgery performed on the wrong patient;

(3) The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient;

(4) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained;

(5) Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance;

(6) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. The term 'device' includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators;

(7) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism;

(8) An infant discharged to the wrong person;

(9) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity;

(10) Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility;

(11) Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

(12) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

(13) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

(14) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;

(15) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. 'Hyperbilirubinemia' means bilirubin levels greater than 30 milligrams per deciliter;

(16) Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;

(17) Patient death or serious disability due to spinal manipulative therapy;

(18) Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

(19) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(20) Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;

(21) Patient death associated with a fall while being cared for in a facility; and

(22) Patient death or serious disability associated with the use of or lack of restraints or bedrails while being cared for in a facility.

(b) The department shall be authorized to use information regarding adverse incidents for the transparency web site created pursuant to Code Section 31-5A-32. The department shall be prohibited from disclosing information that directly or indirectly identifies a patient, employee of a health care facility, or licensed health care professional in connection with the adverse incident.

ARTICLE 3

31-5A-40.

This article shall be known and may be cited as 'Georgia´s Patient´s Bill of Rights and Responsibilities.'

31-5A-41.

It is the intent of the General Assembly that health care facilities, health insurers, and pharmacies understand their responsibility to give patients information pertaining to their health care so that they may make decisions in an informed manner after considering the information relating to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. This Code section shall not be used for any purpose in any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law.

31-5A-42.

(a) As applicable, each health insurer, pharmacy, and health care facility as defined under Code Section 31-5A-31 shall make available on its website a link to the performance outcome and financial data that is published by the department pursuant to Code Section 31-5A-32.

(b) Health insurers shall include in every policy delivered or issued for delivery to any person in this state or in any materials provided to any person notice that such information is available electronically and the address of its website.

(c) Health care facilities may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient´s bill may vary from the average depending upon the severity of illness and resources consumed. The health care facilities may also indicate that the price of service is negotiable for eligible patients based upon the patient´s ability to pay.″

**SECTION 2.**

Article 6 of Chapter 4 of Title 26 of the Official Code of Georgia Annotated, relating to pharmacies, is amended by adding a new Code section to read as follows:

″26-4-119.

All pharmacies licensed under this article shall be required to submit performance and outcome data, as well as pricing information, to the Department of Community Health as specified by the department pursuant to Code Section 31-5A-32. Such data shall be submitted on a time basis as prescribed by the department.″

**SECTION 3.**

This Act shall become effective on September 1, 2007.

**SECTION 4.**

All laws and parts of laws in conflict with this Act are repealed.